

NAVY MEDICINE

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Navy Medicine Returns to Corregidor

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COVER: Malinta Tunnel, Corregidor. World War II veteran RADM Ferdinand Berley, MC, USN (Ret.) and Navy Medical Department Historian Jan K. Herman discuss the 1942 surrender of American and Filipino forces in the Philippines. Dr. Berley would spend the next 2 ½ years as a prisoner of war. The Bureau of Medicine and Surgery will soon release the third video in the series on Navy medicine in World War II. Story on page 8. Photo by Ed Sandford, NMC San Diego.

Admiral's Call

Navy medicine is developing a corporate-level human capital strategy to ensure we are aligned with Navy and Marine Corps operational forces. The Chief of Naval Operations (CNO) has made the development of such a strategy the Navy's top priority—an indication of the important role human capital management will play in our organizational success. The CNO has asked Navy medicine—and all Navy communities—to examine our human capital strategy and evaluate how it is aligned to support Navy and Marine Corps missions.

Our human capital strategy is a plan that states how Navy medicine will manage our workforce in the future and how we best contribute to the combat capability of the Navy and Marine Corps.

Our strategy will encompass the entire range of personnel development, from accession to training to assignments. It will associate Navy medicine's operational requirements with the knowledge, skills, abilities, and tools required by our people to actually perform their work. Finally, it will promote the integration of everyone in our workforce—active and reserve personnel, civilians, and contractors.

As we develop our human capital strategy, we must be prepared to challenge some long standing assumptions and even change the way we plan and conduct our operations. We can no longer afford to operate under the status quo. Navy medicine must transform its culture and personnel management practices to adapt to the Navy's fundamental manpower concept which requires only those uniformed personnel necessary to sustain warfighters. Our uniformed personnel exist to provide medical support to Navy and Marine Corps operational forces, and our uniformed force structure is



based on combat service support. All other services can and will be provided by a growing civilian work force.

As we execute our human capital strategy, we will reevaluate the manpower structure in each of our various medical communities to determine how best to support our requirements. We may determine that we have more of one specialty than we need, or less of another specialty. We must be prepared to change, and realize the improvements that might derive from doing things differently. Like other Navy communities, Navy medicine is assuming responsibility for self-management and planning our future.

Again, our goal is to have the right people, with the right skills, in the right place, at the right time

to fulfill our health care mission.

This transformation effort is not the result of Navy medical community mismanagement or lack of responsiveness, but rather the result of changes to our operating environment. Navy medicine has a bright future and continues to perform superbly, but like the rest of the Navy and Marine Corps, must do so with greater efficiency.

As our human capital strategy is finalized and necessary manpower adjustments are determined, all changes to community-specific manpower and training requirements will be communicated, in advance, to keep our personnel and beneficiaries informed of these actions.

I appreciate your support and understanding as we undertake this important endeavor and help shape the future course of Navy medicine. Our Sailors and Marines, as well as the beneficiary population we serve, deserve no less than the absolute best health care we can provide.

Vice Admiral Don Arthur, MC, USN
Surgeon General of the Navy

NH Bremerton Conducts Workshop to Treat Combat Stress

Larry Coffey

In the first of its kind training within Department of Defense (DOD), a clinical psychologist at Naval Hospital Bremerton presented a 1-day workshop on Eye Movement Desensitization Reprocessing, or EMDR, last August at Ft. Lewis, WA. CDR Mark Russell, MSC, USN, considered the military's top expert on EMDR, presented the workshop to psychologists and psychiatrists from both Madigan Army Medical Center and the Army's Substance Abuse Program at Ft. Lewis. EMDR was approved by DOD in January as one of three treatments of choice for combat stress and post-traumatic stress disorder (PTSD). It is a structured treatment procedure guided by an information processing model that seems to tap into the brain's natural processing abilities by using alternating bi-lateral stimulation—eye movements, auditory sounds or tapping—to focus their attention on the disturbing memories, Russell explained. "Some researchers equate the rapid, back and forth eye movements used in EMDR to what occurs naturally in REM (Rapid

Eye Movement) sleep that has long been viewed as the brain's means to process information, which may provide a simplistic explanation but not tell the whole story," he said. In highly emotionally charged or traumatic memories, the brain is unable to process information adequately, Russell said. People wake up with nightmares, are emotionally numb, or avoid the memory. EMDR appears to work around that problem by having the person remain awake and conscious while applying the eye movements. Since publication of the guidelines advocating the use of EMDR, there has been more interest in looking at other methods of treating PTSD. "I think that with the increased number of veterans coming back from Iraq with combat stress-related symptoms, and with the limited time that mental health professionals often have to work with these patients, providers are looking for other options that may provide rapid, lasting effects," Russell said. Russell has recently treated several medical personnel here who were stationed in Iraq with the Marines,

and have returned with the same type of PTSD symptoms as combat soldiers and Marines. He said results come much quicker using EMDR as opposed to traditional methods. "I would say that two to six sessions of EMDR would be the range, and two to three would be the average," he said. "When you compare that to 12-15 sessions, I would say that is a more manageable way of doing business." Another advantage of EMDR is that patients don't have to verbalize as they do in other treatments. Russell said this accommodates the "warrior mentality" of those who don't want to admit to vulnerabilities or discuss personal issues. "I think that once other medical centers in the military learn about what's going on at Madigan and what they're doing, they will follow," he said. "I hope that this will become the start of people looking to adapt the procedure both in theater, as well as with people coming back from Iraq." □

Mr. Coffey, is assigned to the Public Affairs Officer, Naval Hospital Bremerton, WA.

Lakehurst Naval Health Clinic Medical/Dental Integration

LCDR Gregory R. Cadle, MSC, USN

On 21 May 2004, with patients, family, and friends looking on, the Lakehurst Naval Health Clinic officially became one of the Navy's first fully integrated medical/dental healthcare delivery systems. Also attending the ceremony was ACMM John Iannaccone, USN (Ret.), the only remaining survivor from the Navy's ground crew present the day the German airship Hindenburg burned in 1937.

As Officer-In-Charge, I opened the official ribbon cutting ceremony by welcoming the attendees, and told the audience that this was a "day of alignment, the melding of two separate healthcare services into one integrated healthcare delivery system, a system that allows us to optimize healthcare to our beneficiaries and become a model for Navy medicine in the future."

Traditionally, medical and dental treatment facilities have always operated out of the same fixed facility but functioned as two separate commands. Following the leadership of the Chief of Naval Operations, ADM Vern Clark, Navy medicine has been actively aligning business strategies

to allow for greater resource optimization.

Representing the Commander of the National Naval Medical Center was CAPT Elaine Wagner, DC, Director, Women, Children's, and Community Health Directorate. CAPT Wagner highlighted Lakehurst's strategic achievements to this point in the integration process and challenged the staff to "not be afraid to try something new." As she pointed out, the integration process is "uncharted territory" and will require us all to remain flexible, focused, and open minded. CAPT Wagner concluded her remarks by citing many references, and do's and don'ts from a book by Daryl Conner entitled, *Leading on the Edge of Chaos*. The book stresses the importance of executing business plans and being able to adapt to changes in a business environment in a moment's notice in order to be successful.

CAPT Mark Bathrick, Commanding Officer, NAES Lakehurst, thanked the clinic staff for "bringing medical services to the beneficiaries of Lakehurst before they knew they



Ribbon cutting at NHC Lakehurst.

Photo courtesy of author

needed them" through a series of preventive health initiatives like the Women's, Children's and Men's Annual Health Awareness Fairs.

The program concluded with the ceremonial ribbon cutting in front of the new Lakehurst Naval Health Clinic sign which displays devices of a chief petty officer, hospital corpsman, dental technician, medical officer, dental officer, nurse, and a Medical Service Corps officer.

Lakehurst Naval Health Clinic operates in a family practice, occupational health, and dental services environment, and has an enrolled population of approximately 1,600 TRICARE eligible beneficiaries. □

LCDR Cadle is OIC, Lakehurst Naval Health Clinic, Lakehurst, NJ.

Navy Reservists Reach Out in Western Africa

JO2 Joseph R. Holstead, USN

Members of Navy Reserve Fleet Hospital Ft. Dix, NJ, and other Navy personnel treated more than 6,000 patients in the West African country of Senegal in July 2004 as part of the West African Training Cruise (WATC) 2004 medical outreach program (MOP).

WATC 2004 MOP, which was conducted by Commander, U.S. Navy Forces Europe (NAVEUR), as part of NAVEUR's security cooperation program with West Africa, took place in three phases. The first was a training phase, followed by a mass casualty scenario event. The final phase consisted of medical civilian assistance programs (MEDCAPs) in eight villages.

During the training phase, medical personnel from the Navy Reserve and Senegalese military shared their expertise. Navy members provided information about the latest advances in U.S. medicine and the Senegalese military doctors passed on their medical knowledge, particularly in the area of tropical medicine.

"You've just experienced a graduate level course, a whole semester,

in 2 hours," said CAPT Philip Landrigan, MC, officer in charge of WATC 2004 MOP, summarizing the feeling of Navy and Senegalese medical personnel who attended a lecture given by Senegalese Army malaria expert MAJ Lamine Diawara on 20 July 2004.

The Navy training team was led by CDR James Armstrong, NC, a decorated Vietnam veteran, flight nurse with the University of Pennsylvania Health System in the civilian world, and the exercise's training officer.

"Working and training with the Senegalese improves military to military interoperability and benefits everyone involved," Armstrong said.

Navy Reserve medical personnel lectured on preventive medicine, women's health, pre-hospital assessment, and the role of the fleet hospital's role in Operation Desert Storm.

"This has been an outstanding opportunity to share the knowledge I've gained over the years, both in the Navy and as a firefighter," said HM2 John Brophy, pre-hospital training coordinator for the exercise.

"The Senegalese have been eager to learn different techniques and apply them," he said.

The training phase culminated in a mass casualty scenario event (which also marked the second phase of WATC 2004 MOP). The scenario required Senegalese military and first responders to react to an explosion at a weapons depot.

On the morning of 21 July, Armstrong, Brophy, and HM1 Tom Novak, all of whom were involved in the pre-hospital training during the first phase, met with approximately 30 Senegalese volunteers and applied moulage (simulated injuries) to set the scene. Senegalese explosive experts further enhanced the realistic atmosphere by setting off staged blasts that filled the air with smoke and left fires burning around the scenario area at the airbase in Theis, Senegal.

Senegalese first responders went into action shortly after the explosions as Navy and Senegalese military personnel observed. To aid them in prioritizing treatment for the scenario victims, the first responders used internationally recognized

colored tags that had been donated to the Navy for use in Senegal. The different color tags indicate the immediacy of treatment needed, making a moot point of the fact that the words on the tags were in English, and French is the official language of Senegal. For example, a red tag indicates immediate treatment and yellow means delayed.

“The information I’ve learned here is very important and has given me a new understanding of how to approach trauma,” said Senegalese SGT Massogui Mbaye.

July 21st also marked the beginning of the MEDCAPs, the third phase of WATC 2004 MOP, in the village of Pout. U.S. Ambassador to Senegal Richard Roth visited the village, along with RADM Jerry West, Deputy Chief, Bureau of Medicine and Surgery, Reserve Affairs, to meet with their Navy team and the villagers and to mark the occasion.

“The quality of care provided by the staff of Fleet Hospital Ft. Dix is most impressive and significantly enhances the diplomatic relations of our two countries” West said.

To make the MEDCAPs run smoothly, nurses, working with translators, received the villagers, and determined which department they would visit based on the symptoms they described. To allow medical personnel to see the maximum number of people, each patient could visit one department (although parents could take their children to a department different than that which they chose).

Divided among dental, medical, women’s health, pharmacy, and optometry departments, and with the assistance of Senegalese military medical personnel, Navy supply and



US Navy Photo by LT Mark Duennig

Members of Naval Reserve Fleet Hospital Ft. Dix form a human chain to unload medical supplies in a village in rural Senegal.

administration support, and translators from various organizations, the WATC 2004 MOP team treated 6,189 people at MEDCAPs between 21-19 July.

“It has been a fantastic experience to be able to help those who do not have the same opportunities for medical care as people in the U.S.,” said LCDR Walter Klein, MC. “It is both gratifying and humbling,” he said.

During the MEDCAPs, the dental department extracted 1,246 teeth; the medical department saw 4,266 patients; the pharmacy dispensed drugs to 5,003 patients; and the optometry department gave away 913 pairs of recycled prescription eyeglasses that had been donated by the Lions Club of New Jersey.

The year 2004 marked the third WATC medical outreach. The first took place in Togo and Ghana in 2002. The second was in Ghana in 2003. In 2004 the upward trend in the WATC MOPs continued, with WATC 2004 MOP personnel achieving the highest level of patient contacts (pa-

tients treated plus pharmacy visits) thus far with 11,192. (The WATC exercise, which did not include naval vessels this year but has in the past, is itself over 30 years old.)

While the numbers of patients helped is very impressive, the individual successes capture the essence of exercise.

“At the second village [MEDCAP], an old man who needed three people to help him walk because he could not see was escorted into the eye clinic,” said HM3 Dennelle Roberts who worked in the optometry department.

“He could not even sit down without people helping him,” Roberts said. “We found a pair of glasses that most closely met his needs, put them on, and his face lit up,” she went on to say.

“He walked out of the eye clinic on his own.” □

JO2 Holstead is a journalist at the Navy Information Center, Ft. Schuyler, Bronx, NY.

Sailors Fight to Save Lives in Deadly Sunni Triangle

CPL Samuel Bard Valliere, USMC

Picture grabbing hold of a young man's hand as he fights to stay alive, while you reassure him that he will live to see his family again after shrapnel just tore into his body. Now imagine fighting just as hard as he is to keep that promise.

The lives of Navy doctors, nurses, and corpsmen have revolved around situations like this since they set up the 1st Force Service Support Group's Surgical/Shock Trauma Platoon here at Camp Taqaddum, Iraq in March 2004. The platoon acts as a bridge between combat and follow-on care for many wounded troops in Al Anbar Province.

When a service member is injured, one of the first priorities is to get him or her to life-saving care. Often, the wounds sustained require immediate attention just to ensure he or she will survive a medevac to one of the Army's large combat support hospitals located away from the embattled Sunni Triangle.

That is where the healing touch of the S/STP's personnel comes in. The 60-person platoon, comprised of 38 corpsmen, 8 doctors, 8 nurses, and 6 Marines, works to save lives by performing emergency operations ranging from stabilizing gunshot wounds and replacing spilled blood to massaging a stopped heart back to life.



Photos courtesy of author

Navy doctors, nurses, and corpsmen wait for a wounded Marine to arrive.

The S/STP is comprised of doctors with various specialties, allowing the team to deal with almost any situation.

"Basically," said CDR Darin Garner, MC, a surgeon in the unit, "if the wound is below the neck, one of the unit's eight doctors probably specializes in it. If the injury is neurological or in the eye, we send them directly to the combat support hospital," he said. "No more than 5 minutes after the unit opened for business on 23 March 2004, the first patient was carried in," said HN Ramon Salinas. Like all floods that begin with a single drop, so too did the mission here.

The platoon has since treated more than 300 people with injuries sustained during firefights, explosions, and non-combat related accidents.

When the Sailors are finished stabilizing a patient, they send him or her to one of two Army hospitals in Iraq, which provide more advanced care and are equipped to hold patients for a longer period of time. The ward tents at the S/STP are only able to hold up to 20 patients at a time for about 72-hours.

"The platoon's painstaking efficiency and care have helped it to earn a reputation among the front-line troops over the course of the deploy-

ment,” said HM2 Jeremy Franco, a surgical technician with the unit.

Even the 1st FSSG’s commanding general, BGEN Richard S. Kramlich, stopped by to pass word from the Marines of 2nd Battalion, 4th Marine Regiment (2/4), whose E Company has suffered more casualties than any other Marine unit in Iraq.

“BGEN Kramlich told us that 2/4 said if they could get over here alive, they know they’re going to make it,” said Franco.

An E Company Marine, recovering at the S/STP after an enemy mortar blasted shrapnel into his leg, echoed those sentiments. “A lot of guys back home are still alive because these guys did a lot for them,” said CPL Robert J. Hernandez, an infantryman.

The desert duty here has been a learning experience for the unit’s Sailors, many of whom have worked in military hospitals but have never seen so many traumatic cases.

“You see a lot of things a lot of the medical community doesn’t,” said Salinas.

That is precisely why many of these Sailors made the decision to be a part of Navy medicine.

“The reason a lot of us go into this field is because you can see such a significant impact on an individual casualty’s life,” said CAPT H.R. Bohman, MC, a general surgeon. “The sailors will feel the 7 months out here added meaning to their lives.”

Last year, during the I Marine Expeditionary Force’s push through the country, the Navy medical system in Iraq was set up much differently.

The Sailors were forced to adjust to the mobile nature of the battlefield by having to constantly pack up and move toward the fighting.

This time, the 1st FSSG placed its surgical units in key, static locations,

to where we think patients are going to be,” said Garner.

Though well settled in here, the unit is mobile in nature and able to move at an hour’s notice to a different area of the country to support heavy, sustained combat operations for as long as is necessary, making it easier to get troops to immediate medical aid.

While the vast majority of the injuries are combat related, the Sailors treat some walk-in patients also, said Garner. The platoon has dealt with appendectomies, heat-strokes, and heart attacks.

Insurgents and civilians injured during combat also get sent to the platoon for emergency care. Everything is done to stabilize them before they are transported to local hospitals, said Garner.

“We had this one Iraqi family that got caught in the crossfire of a firefight. It was literally two or three generations of this family,” said Franco, who said the team was able to save almost all of them. “Bringing somebody from the brink of death to give them another chance at life is the thread that holds

the tight-knit platoon together,” said Franco.

“You know that you helped save somebody’s life and helped them get home to their families,” said SN Ron Brizuela. □



Crowded around a stretcher, a group of Navy doctors, nurses, and corpsmen operate on a severely wounded Marine who was injured when a roadside bomb detonated near his vehicle on 3 April 2004.

making it easier for mass numbers of injured troops to receive treatment.

Five similar units are spread throughout Al Anbar Province. They vary in size and slightly in capabilities, but ensure lifesaving care is available anywhere I MEF troops are located.

“We’ve centralized so patients are brought to us, as opposed to moving

CPL Valliere is Combat Correspondent, 1st FSSG Public Affairs, Camp Pendleton, CA.

“Guests of the Emperor” Release

Following the Japanese attack on Pearl Harbor in December 1941, a seemingly invincible Japanese war machine quickly extinguished U.S. power in the Pacific. When the Philippines fell to the enemy the following spring, thousands of American and Filipino defenders became prisoners of war. Included in this tally were 11 U.S. Navy nurses.

For some, the days, weeks, and months of brutal captivity, forced labor, starvation, and boredom became a distant blur as time tended to sift out the worst of the horror. Others would never forget their days as prisoners of war. The sinister brutality inflicted upon these unfortunate prisoners by their captors is almost beyond comprehension. Torture, sadism, beheadings, death ships, and starvation were routine.

The soon to be released 30-minute video, “Guests of the Emperor,” in the Bureau of Medicine and Surgery’s six-part series, *Navy Medicine at War*, tells their story through the eyes of the POWs themselves. “Guests of the Emperor” is the third video to be released. “Navy Medicine’s Trial by Fire: December 7, 1941” and “Navy Medicine at Normandy,” are available on DVD or VHS.

You may order “Guests of the Emperor” and copies of the other releases from: Visual Information Directorate, NMETC, Bethesda, MD, 301-295-5595. Please specify DVD or VHS format. □



Photos by Ed Sandford, NMC, San Diego

Former prisoner of war RADM Ferdinand Berley describes the aftermath of Corregidor’s surrender in the ruins of the island’s former Army hospital.



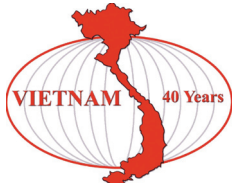
Return to Bilibid Prison:
 Standing above the prison yard in what today serves as Manila's municipal jail, Dr. Berley relates his experiences as an inmate there during World War II.



(Left) Beside the ruins of Middleside Barracks, Dr. Berley recollects the Battle of Corregidor. Videographer Dale Knorr of Naval Medical Center, San Diego records the scene.

(Right) Following Corregidor's surrender, the Japanese herded thousands of American and Filipino prisoners into the 92nd Garage, a paved lot where military vehicles were normally parked. Dale Knorr videotapes Dr. Berley as Navy Medical Department Historian Jan Herman looks on.





Charlie MED

A Physician's Vietnam Journal

CAPT William B. Mahaffey, MC, USN (Ret.)
Part V

Creature comforts are essential in any situation, though they vary in significance according to the circumstances. The creature comforts we enjoyed at a medical battalion were vastly more pleasurable than those enjoyed by Marines in the field. We never forgot that. But they were far fewer than those enjoyed at NSA Hospital near Danang or on USS *Repose* (AH-16) out in Danang Harbor where air-conditioned living quarters, flush toilets, hot showers, and chilled drinking water were standard comforts. I wonder if they served Spam on *Repose*?

One important creature comfort at Charlie Med was the shower. When I arrived, the officer's shower was an unenclosed stall made of 2 by 4s. The users' privacy and modesty had not been considered. A crude ladder leaned against the side of the structure. At the top was a 55-gallon barrel fitted with a kerosene-fired immersion burner borrowed from the galley. Lighting the burner was tricky so its use was limited to cool weather. Normally, each of us kept a 5-gallon can of water in the sun all day. We would then climb the ladder, dump the can of warmed water into the barrel, then return quickly to the stall to enjoy a brief 5-gallon shower as water was allowed to flow through a tin can with holes punched in the bottom.

On my second day in country I discovered how the shower was used. Naively and without asking permission, I picked up a 5-gallon can of water a senior dental officer had been warming all day. Perhaps I was thinking that such cans of water were distributed for our convenience. I used it for my first shower in Vietnam. When I finished, the dentist asked me, "Did you enjoy your shower?"

Early in the game, hyper-chlorinated drinking water was towed in to Charlie Med in two-wheeled "water buffaloes." Containers were then filled for various purposes from those centrally-placed water buffaloes. By late summer when Marine running water was being piped in from a central source, a common shower tent had been built, complete with waist-high outer walls, multiple showerheads, soap dishes, and lights. Water for the showers was stored in a cumshawed wing tank from a former jet fighter. The sun would warm the stored water considerably during bright days and a warm shower in the evening, though the temperature of the water could not be regulated, became a real luxury that we soon took for granted.

Our galley or dining facility was run by the Marines. It served us well, though there was never a relish plate. And they never offered "chilled this" or "fricasseed that." Everything was

thoroughly fried or roasted or boiled or mashed, though occasionally we had steaks to broil.

Each of us had his own mess tray and utensils suspended from a piece of wire. As we approached the mess hall, we first encountered a large garbage can of water heated to boiling by an immersion burner. We would hang onto the piece of wire and dip our mess gear into this cauldron, ostensibly to sterilize it.

Breakfast invariably offered canned orange juice, toast or dense sticky buns, eggs (sunny side up or down, but never scrambled) and bacon or fried Spam. Huge pancakes and sausage links occasionally provided variety.

Large portions of that day's menu selections were served (not "presented!") cafeteria style absolutely devoid of decorations such as parsley, herbs and the like, and eaten at tables in a screened "dining room." Lettuce and fresh salads were unknown. The reconstituted milk and the hyper-chlorinated water were unappetizing so we usually drank bug juice (Marine Corps Kool-Aid) or coffee. Baked Marine desserts were plentiful at mealtime and for snacking day and night, but they were certainly not delicate. The Marines' favorite seemed to be an inch-thick dense spice cake made from a mix and topped by a

very thick layer of generic khaki frosting. Also available any time of day or night were makings for cold Spam sandwiches. Occasionally very soft tan—almost khaki—Marine ice cream showed up, but it was normally diverted to the patients' trays. After a meal, we each scrubbed our mess gear in a hot soapy cauldron, then dipped them again into plain hot water. Some fresh bananas, melons, mangos, and pineapple which could be consumed safely were eventually procured from the local economy. When a visit to the mess hall just didn't sound very appealing during quiet periods, we snacked in our hooches on the surprisingly good items found in commandeered C-rations, or on items from the PX, or on precious goodies received from home.

Early in 1966 the occupants of each hooch in the compound were given the option of hiring a "House Mouse" or Vietnamese woman who would do laundry and tidy up our living spaces in the hooch. No matter how well they scrubbed our uniforms and skivvies, drying laundry in Vietnam's humidity was a slow process especially during the rainy season. Our "House Mouse" was named Mỹ. The Vietnamese language is tonal and the real meaning of a word depends on the proper rising and falling pitch of the voice. We apparently never mastered the pronunciation of Mỹ's name since she would usually giggle when called. We lost Mỹ's services when it was discovered that she had a positive tuberculosis skin test.

Occasionally we had an all-hands party in the OR. The fanciest party was when drinking containers had been fashioned from small hollowed-out local pineapples. To the juice made from the pulp was added 7-Up, ice and just a little "gilley" or medical grade ethyl alcohol. Each Quonset

housed two ORs. During that party in one OR, an emergency appendectomy was performed in the other OR in the same Quonset. The party continued.

Beer and distilled spirits, as well as a variety of soft drinks, were always available on the honor system in the Clubs. A cold beer or a gin and tonic sometimes settled well, especially after supper while waiting for a movie to start. But without any specific orders, we had a very responsible attitude toward alcohol in a compound where casualties could swamp us at any minute. Our commanding officer dealt sternly with the rare abuser. One such senior officer was "restricted to quarters," meaning that except for work and meals, he remained in his hooch for a considerable period.

A constant source of electricity was essential to our work. Near the helicopter pad, two of our four noisy diesel generators were always running. Only rarely did we lose all power. At those times, I think the dead silence was more noticeable than the absence of lights.

Was money a creature comfort? It was! It now seems unbelievable that in those days, long before the convenience of direct deposit of military paychecks, paper paychecks of the "Do not Fold, Staple, or Mutilate" type were issued to us twice a month. Unless, of course we had directed an allotment to a spouse or some financial institution. Our paychecks could either be cashed at the BX or they could be mailed back home to a bank. I wonder how many paychecks were never cashed. To avoid a black market situation, we could not spend greenbacks in Vietnam, only ornate MPCs or Military Payment Certificates issued in various dollar and fractional denominations. For any dealings with the local economy, such as buying souvenirs, paying a House Mouse, or, I suppose, even settling up with a prostitute, some MPCs had to be converted into Vietnamese Dong currency at the rate of a thousand or so Dong to the dollar.

The bulk of our patient load at Charlie Med consisted of combat



Photos courtesy of author

Author at work in new C-Med OR, 4 October 1966.

casualties requiring surgery, but there were many patients in other categories to keep our medical personnel busy.

Malaria patients among the Marines were surprisingly numerous. There were also surprising numbers of Marines with disabling diarrhea who required admission to our medical wards so that their severe dehydration could be corrected. During the cooler wet winter nights of the monsoon season, a number of Marines arrived at Charlie Med with pneumonia.

Sexually-transmitted diseases, primarily gonorrhea and some syphilis, are common in any combat zone, though they were often treated at the battalion aid station level. But in Vietnam, we were seeing a new problem. Gonorrhea normally responds promptly to penicillin and is usually not a therapeutic challenge, but in Southeast Asia our physicians were beginning to see a form of gonorrhea which did not respond to penicillin. It was labeled PPNG or penicillinase-producing *Neisseria gonorrhoeae*. This new strain of the gonorrhea bacterium produced penicillinase which destroyed penicillin in the body at the site of the infection. These numerous PPNG patients were retained on the wards long enough to do antibiotic sensitivity testing so that the right antibiotic could be started.

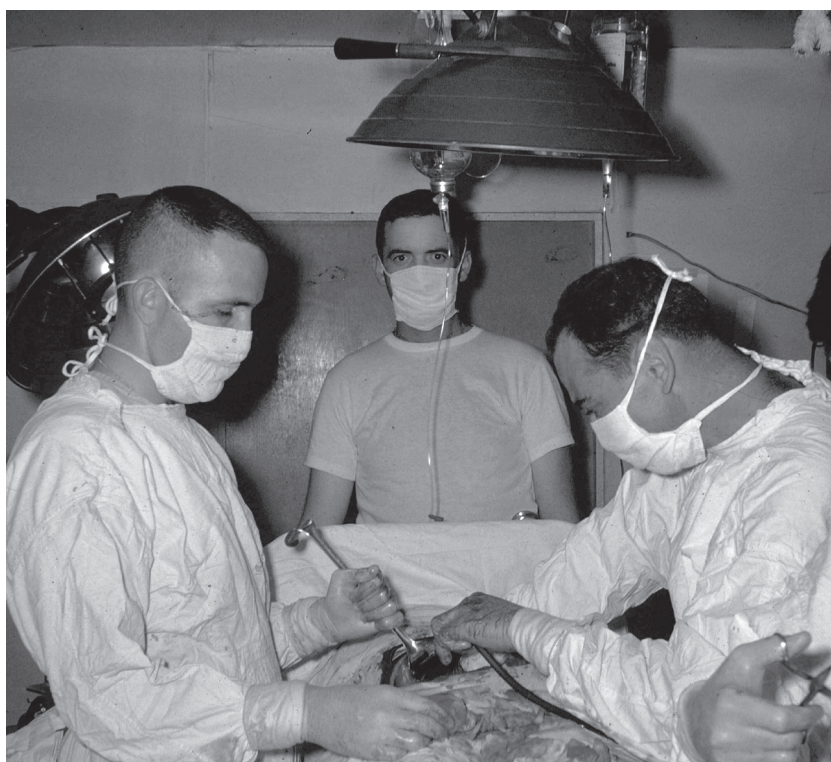
Our psychiatrist was kept busy seeing and treating many combat fatigue victims and others who temporarily went off the deep end while facing the realities of war. His office and hooch were away from the other clinical areas of Charlie Med. Near his office were two wards housing his patients.

From any large population of young adults such as the 3rd Marine Division, a goodly number of appendicitis cases can be expected,

unrelated to war. During a period of heavy casualties, it was not uncommon to hear that the next patient coming to the OR would be an “appy” or appendicitis patient. If the seriously wounded casualties were particularly numerous, however, an appendicitis patient could safely be put on hold for some time with intravenous antibiotics and other conservative measures.

Injuries ran the scale from small and almost insignificant to some of the most incredibly horrendous wounds imaginable. One of the smallest wounds that I recall in the OR was an Air Force man who caught his wedding ring on something as he jumped to the ground from a parked aircraft. This injury stripped or avulsed all the skin from his ring finger. It seemed so insignificant compared to other injuries we took care of but the services of a skilled surgeon would be required to preserve that finger’s function.

Another frequent but relatively minor injury was that resulting from a Marine stepping on a concealed punji stick in the jungle. A punji stick is a pencil-sized piece of steel with a very sharp barb on one end. Like a barbed fishhook, it cannot easily be removed from even soft tissue. Several of these punji sticks would be imbedded vertically in a slab of concrete or mounted on a piece of wood so that they could be concealed in the underbrush where Marines on patrol might walk or run. It was rumored that punji sticks were coated with feces. When a running Marine stepped forcefully on the punji stick, the sharp barbed tip immediately pierced his boot and foot. While pain was severe, the injury was not all that serious. However, it disabled the Marine by having a heavy slab of concrete or wood painfully and firmly attached to his foot until he could be removed to a location where



Surgery in original C-Med OR.

the barb could be cut off and the punji stick removed. In the field it also effectively incapacitated one or two uninjured Marines or corpsmen when they had to carry the injured man.

On display in Charlie Med's triage building was a huge trap, nicknamed a bear trap, and operating like a huge rat trap. Early in Charlie Med's presence in Vietnam, a Marine was brought in with his leg in this bear trap.

There were a number of Marines whose only wound was a belly wound resulting from a piece of flak ripping an opening in the abdominal wall. Usually, a sizable loop of small or large intestine would be protruding through the wound when the man arrived at Charlie Med. Though this injury would require a general anesthetic, only a fairly brief surgical procedure would be needed to check the gut for perforations and then close the wound. This Marine would be up and around in no time. After USS *Repose* arrived, casualties such as these would recuperate on the hospital ship and—unfortunately—return to battle unless this injury had earned him his second Purple Heart in Vietnam.

There were several casualties who will linger in my memory forever.

One night when casualties were heavy, someone told me that an incoming Marine was calling for me by name. It was Mike Brown, though I forget his enlisted rank. Earlier in the year he had been one of the many severe diarrhea patients we cared for at Charlie Med. Though I am anything but a diarrhea expert, I, like almost every other specialist physician, looked after a few of the non-surgical patients in our wards. Mike Brown was one of those. When he came in with both legs mangled from an exploding Bouncing Betty land mine, shocky though he was, he had the presence of mind to ask for his diarrhea doctor. I adminis-

tered his anesthetic and recall shaking hands with him as he was medevaced out. Unfortunately, we as physicians had no easy way to follow up on patients who were treated at Charlie Med. Occasionally, a patient whose well-being one of us was particularly concerned about would be given an addressed envelope with the request he drop us a note. To my surprise, I heard from Mike Brown before I left Vietnam and we exchanged occasional letters. After I returned to the States and retrieved my car from storage, I was able to pay this Marine a rather emotional visit in the Oakland Naval Hospital.

Another memorable patient was a HM1 Anderson. I had never met this unfortunate corpsman prior to his arrival at Charlie Med one night with both legs and one hand blown away. I have a post-op picture of this somber corpsman in the ICU/recovery room being fanned gently by a grinning Vietnamese boy named Nguyen. This orphaned boy had come in weeks earlier as a casualty of the war with an abdominal wound. While his colostomy healed, he cheerfully helped out on the ward. Later conversation would reveal that HM1 Anderson's parents and my parents had attended the same church in Akron, OH, before either of us was born. I was disappointed that I never heard from this fine corpsman once he was medevaced out.

Many of our casualties sustained single wounds in the many firefights that were typical of that war. No parts of their bodies were exempt from injuries, though helmets and flak jackets protected their most vital organs to some degree. If the rounds causing these injuries passed through only soft tissue without shattering a bone, severing a major artery, or destroying a nerve, they were indeed fortunate. Their injuries could be cleaned up

promptly in the ORs with minimal blood loss.

One such casualty, a lance corporal, was of medical interest. A round of ammunition penetrated the soft tissue just above his left clavicle. Fortunately, it missed important nerves and vessels in that area. But the round did strike the Marine's metal LCPL rank device on his collar, driving it through soft tissue into the very apex of his thoracic cavity and causing a pneumothorax. Although he was medevaced out, possibly to the hospital ship, his recovery would certainly be prompt.

Many Marines who were injured by a single round of ammunition were not so fortunate. All too many of them died instantly despite helmets and flak jackets when the round struck a vital organ or vessel.

Research shows that a rapidly moving projectile passing through soft tissue can destroy relatively large amounts of that tissue, even if vessels, nerves, and bones are missed. And when these vital structures are also damaged a serious injury can become even much worse. Such casualties were common in our ORs, but because they were usually limited to only one part of the body, the surgical procedures were relatively straightforward and little blood had to be transfused.

Perhaps because this next gruesome subject is still so difficult to think about, I leave a discussion of the horrible injuries resulting from exploding land mines until last. Every aspect of these incomprehensibly horrendous wounds can only be described in superlatives. The greatest number of Marines were killed and injured by this one detonated explosive device alone. In fact, land mines caused the highest mortality rate of all battle wounds. The injury was most

destructive to muscle mass, and was the most heinous destroyer of entire limbs. These wounds required, by far, the most massive blood transfusions during surgery. Land mines produced largest category of patients in the Navy's orthopedic rehabilitation hospitals where prosthetic limbs were fashioned and the ability to ambulate was slowly relearned.

I do not claim to know much about land mines. I have never seen one in a combat zone. I have never been within miles of an exploding land mine. However, I am intimately familiar with the horrific mutilating injuries that exploding land mines cause.

I am told that most land mines in Vietnam were of the Bouncing Betty type. Once tripped by Marines on patrol, the Bouncing Betty rises a foot or so above ground level before exploding laterally, sending huge numbers of lethal high velocity missiles in every direction. Speaking as one who has neither seen a Bouncing Betty nor even received a training lecture about them, I have been told that when a Marine trips one of these land mines in combat, an audible sound is produced followed by a slight delay before the actual explosion. During this slight delay, the Marine instinctively begins to turn away from the land mine so that the force of the impending explosion is directed toward his backside. Factual or not, we cared for many, many Marines who had been brutally injured in land mine explosions. An enormous amount of muscle tissue, usually from the posterior aspect of their thighs and legs, was destroyed and, all too often, the

long bones of the legs were shattered beyond repair.

When a single high velocity round encounters soft tissue, a zone of dead or devitalized tissue results along its path. Fortunately with a single projectile, this devitalized tissue is relatively small in volume. With a land mine, however, the Marine's body is peppered with large numbers of high velocity projectiles known as flak. Each piece of flak results in the devitalization of a golf ball - or tennis ball - sized sphere of muscle with corresponding damage to the skin it penetrated. In the operating room, all this devitalized muscle and skin must be debrided or removed surgically to permit even slow healing. This debrided muscle tissue bleeds very freely. Since many of the injuries included the buttocks and upper posterior portions of the thighs, the use of a tourniquet was often impractical.

Land mines are not intended to target one victim. All the Marines on patrol in closest proximity to an exploding land mine are either killed outright or are very brutally injured. Those victims farther from the explosion receive fewer and fewer severe injuries. From a single land mine explosion, we would usually receive a number of dead Marines, a few very severely injured Marines, and perhaps dozens of Marines with various serious but not life-threatening injuries.

With no attempt to be melodramatic, land mine explosions were unfortunately our bread and butter. The casualties resulting from a single land mine explosion could swamp our facilities for a day or longer. Our

personal reactions to what we, as medical personnel, saw and cared for were our own very private concerns. I do know that we were at first stunned and numbed by what we experienced when we first arrived at Charlie Med. Later, we were overcome by more of an overpowering feeling of disbelief. Each time a load of these casualties arrived, we thought, "How can there possibly be any more out there?"

While caring for land mine injuries to the lower extremities in the operating room, surgeons made every attempt to preserve one or both knee joints when possible. During rehabilitation with prosthetic limbs, having even one functional knee joint makes it far easier for the patient to learn to walk again.

If these patients had been first treated in a conventional hospital, they would have immediately been placed in traction post-operatively. But we did not have necessary weights, pulleys, and ropes in a medical battalion to provide such traction. Furthermore, it would be impractical—almost impossible—to transport a patient in conventional traction on a medevac bus or a medevac plane to some distant hospital. So surgeons placed many of these severely mutilated patients in what is called a spica cast, a bulky plaster brace of sorts extending from as far below the hips as necessary up to the rib cage, leaving the necessary openings for hygienic purposes. In this relatively immobile condition, the casualties could be safely and much more comfortably transported on a litter to a helicopter, bus, or airplane. (To be continued) □

Dr. Mahaffey is retired and resides in Upper Sandusky, OH.

Remembering the Fuji Fire: 19 October 1979

Bill Doughty

Former hospital corpsman Murray Simpkins remembers hearing the strange sound over the howling winds and driving rain outside the Battalion Aid Station (BAS)—explosions—“Whump” . . . “Whump” It seemed unreal on that cold afternoon 25 years ago, 19 October 1979; explosions and a firestorm in the middle of a typhoon and driving rain. The disaster would become known simply as the “Fuji Fire,” taking the lives of at least 13 Marines and wounding 70 more.

Typhoon Tip, one of the worst storms in Japan’s history, hit the Marine Corps Training Camp at Mt. Fuji especially hard, dislodging and breaking a fuel bladder of the 2nd Battalion, 4th Marines Battalion Landing Team.

Gasoline floated on a torrent of rainwater into the Marines’ living area. Marines smelled the fumes just before explosions rocked the encampment.

Open-flame space heaters in the Quonset huts ignited the gas, causing the “whumps” Doc Simpkins and his crew could hear at their BAS.

“We had a radio net set up and heard yelling from someone on the frequency about a fire. Then we lost contact,” said Simpkins. He later learned that the call had come from Weapons Company, which was hardest hit.

“I checked outside and saw the first casualty come out of the storm toward the BAS. He was burned almost totally from the knees up. We kind of forgot about the typhoon after that, and corpsmen and Marines ran into the storm to help their fellows,” said Simpkins, now a retired hospital corpsman living and working in Yokosuka.

Visibility was cut and the gasoline fires blocked access to casualties, Simpkins remembers. He witnessed heroic acts as Marines ran or drove through flames to rescue their buddies.

“Most of the casualties were in the first row of huts, the Weapons Company area, which ignited one after the other like dominoes,” said Simpkins. “After that, the flames followed the course of the water, hitting huts at random down the camp and cutting off access to some areas.”

People enveloped in flames jumped or were thrown into ditches filled with rushing water from the flash flood.

“I saw a lot of ordinary people do extraordinary things,” said Simpkins. “They say that the cream rises to the top when faced with a life or death situation. It basically filled me with a sense of awe and trust in my fellow man to witness that.”

Simpkins and his team provided immediate triage and care on scene and sent 45 severely wounded Marines to five local Japanese hospitals.

Army, Air Force, and Navy medical assistance arrived on scene as soon as the winds and rain subsided and roads became passable. They brought much-needed oxygen, bandages, and other supplies. Until that moment, though, the care of the badly injured Marines rested with a small crew of mostly corpsmen.

With only one oxygen regulator and nine small cylinders on hand in their ward block, the 2/4 Battalion Landing Team was overwhelmed very quickly.

“We were a combat-ready BLT trained for expected combat injuries,” said Simpkins. “The mass casualty scenario was not an expected event.”

Simpkins followed primary protocol and training to stabilize and transport casualties to the next echelon of care.

Former Marine SSGT Skip Stocks was outside when the fire started, trying to protect the supply compound from the typhoon. “I remember being in the back of a six-by, helping another Marine up; and the skin of his arm came right off in my hands like a snake shedding its skin.”

“I remember going out to help medevac civilians to a local hospital,” said Stocks. Marines, Sailors, and Japan Self Defense Force personnel worked together as teams. “I remember the hospital was overflowing—patients (Marines and Japanese nationals both) having nowhere to sit or lie but on the floor.”

“I remember the smell of death when we rode back into that silent, still smoking camp 3 days later,” he said.

Simpkins keeps some photos of the aftermath and cleanup efforts and some faded yellow news stories from *Pacific Stars & Stripes* in an old photo album.

“We were told to keep a scrapbook to help us deal with our feelings,” he said. For years, we would feel ill if he smelled gasoline or came in contact with fog.

The former chief hospital corpsman and independent duty corpsman, Simpkins works as a computer engineer at U.S. Naval Hospital, Yokosuka.

Simpkins says it’s important to remember the horrors of the event in order to learn the lessons of preparedness for any contingency. He and his team had been standing by for any minor injuries caused by the typhoon. Instead, they were overwhelmed with devastating casualties from an unexpected fire.

“You can do your best to hone your skills and be prepared for as many possible scenarios, but remember to return to the basics when faced with something not planned for,” said Simpkins.

“I also believe ingenuity and improvisation play a great part. When it hits the fan you won’t have time to read the *Manual of the Medical Department*, but its hard cover makes a reasonable short arm splint and its pages cover burns or wad up to plug a wound when you don’t have any more real dressings.”

Today, Japanese and American flags wave over a memorial at Camp Fuji. A stone carving reads: “In memory of the Marines and Sailors of BLT 2/4 who died or were injured during the typhoon and fire, 19 October 1979.” □

Mr. Doughty was assigned to the Public Affairs Office, U.S. Naval Hospital, Yokosuka, when this article was written.



Photo courtesy of author

Memorial dedicated to those who were lost or injured in the fire.

Enhancing Today's Warfighter

JO3 Therese M. Campbell, USN

The restructuring of the Navy to become smaller and more efficient, joined with constantly evolving mission and tactical requirements, makes it essential for each warfighter to be at peak operational readiness. The Navy and Marine Corps team is among leading militaries around the world that operate state of the art equipment, ships, and aircraft. With today's technology becoming more and more advanced, the Sailor or Marine who operates the equipment must be highly trained and prepared.

"Often in developing a warfare capability we pinpoint the weaponry and the equipment that Sailors and Marines use," said Dr. James Hodgdon, a physiologist who works at the Naval Health Research Center (NHRC) in San Diego. "We don't look enough to the capability and development of the people. We have a preventive maintenance schedule (PMS) for everything in the Navy except the Sailor, and part of what we do here is put together information to help the Sailor or Marine."

A 29-year veteran, Hodgdon is part of a small team of physiologists

and psychologists who work to maintain and enhance the performance of the modern day "Warfighter" in the Warfighter Performance Program. The Warfighter Performance Program is a department at the NHRC that conducts research related to understanding human performance and how performance is affected during military operational environments. Emphasis is placed on the measurement and understanding of the processes that lead to physical and mental performance degradation and the development of countermeasures to maintain or enhance performance.

A small experienced team of Navy and civilian physiologists and psychologists gather information from a number of different locations onsite, at the laboratory at the NHRC command, or out in the field. They gather information associated with the measurement, maintenance, restoration, enhancement, and modeling of human performance in military operational environments.

The performance program involves human performance studies

that focus on identifying methods to support the operational capabilities of personnel deployed.

"We currently have 20 ongoing research projects," said physiologist and Warfighter Performance Program manager, LT Sheri Parker. "We look at the occupational, environmental, and physical challenges that service members face. We also work on ways to prevent performance degradation when exposed to uncontrollable environmental factors such as high altitudes and poor weather conditions. By preventing these problems, the performances of the warfighter can be enhanced."

The team observes Sailors and Marines, occupational demands, physical fitness, environmental effects, the ability to multi-task, and altitude exposure to see how it affects their job and mission. "To enhance the performance of the warfighter is our goal," said Parker. "We are here to help the warfighter do their job better, faster, safer, and more accurately."

The Warfighter program has successfully conducted numerous stud-

ies such as neck and back strain in airborne early warning aviators, new strategies for reducing oxidative stress associated with Marine Corps operations in harsh environments, and the study of body composition for Navy personnel which is used in the semiannual Physical Readiness Test (PRT).

Currently the team is researching to see if the elliptical training machines can be used as an alternative for the 1.5-mile walk/run portion of the PRT. Another ongoing study is pharmacological intervention that is designed to prevent altitude decrements at higher elevation, or high altitude sickness. This may apply to certain situations that service members may find themselves in. As an example, Marines who are deployed to Iraq to assist in the war efforts may be required to rapidly deploy to higher altitudes for a mission. This may cause them to suffer from acute mountain sickness. They may also suffer from high-altitude pulmonary edema, which involves fluid accumulation and swelling in the lungs and can cause heart failure from the increased pressure in the pulmonary veins.

Another effect is the high-altitude cerebral edema cardiovascular effect. This occurs when high altitudes have

damaging effects on the brain. Researchers are working on a treatment with the pharmacological agents acetazolamide and ginkgo biloba extract which are specifically designed to prevent or lessen the symptoms of altitude decrements for a person on forced, rapid ascents. Ginkgo biloba extract is most commonly seen in vitamin packs and teas. In this instance it can improve brain and memory function by enhancing oxygenation, protect the heart and restore blood circulation, help preserve general vitality and health, fight common allergic reactions, and correct vision and hearing problems. In treating the effects of altitude decrements, it acts as an antioxidant, reducing stress on tissues that have been injured by low oxygen levels. NHRC has four other laboratories located across the country whose primary goal is to enhance performance, health, safety, and readiness of military forces. "The center's role is to promote, protect, and assist the warfighter in areas of physical and mental readiness," said Parker. However, NHRC is the only lab in the Navy to conduct basic and applied research of human behavior and how human behavior can be affected by both the environment and medicine. The center focuses on areas of study surrounding human

behavior, including behavioral psychopharmacology, cognitive psychophysiology, environmental medicine, ergonomics research, and health psychology. Each can be related to how certain types of prescribed medicines not only enhance a Sailor or Marine's behavior and performance, but also minimize the adverse effects that may occur in harsh environmental conditions. Parker said the center assists the warfighter by evaluating how effective nutritional programs are for personnel who have weight problems, how service members can handle multi-tasking, and how service members can adapt to new environments while enhancing their performance. In addition to studying this, the center also assesses what equipment design can maximize productivity by reducing operator fatigue and discomfort. As the mission of Sailors and Marines places more demand on an individual's mind and body, programs like the Warfighter Performance Program at NHRC continue to make progress on improving the performance and equipment of the modern elite "Warfighter." "In the end, we are here to serve them," said Parker "They are our end product." □

JO3 Campbell is assigned to the Navy Public Affairs Center, Naval Base, San Diego CA.

LCDR Francis Eastman Locy, MC, USN

Founder of the Naval Postal Classification System

CAPT Murray C. Norcross, Jr., MC, USN

There have been many heroes of Navy medicine in our country's 229-year history. One who may surprise you is LCDR Francis Eastman Locy, MC. LCDR Locy contributed not only to the Navy, the Marine Corps, and our nation as a courageous surgeon on the battlefield, but also as a major contributor to the field of philately, more commonly known as "stamp collecting." Dr. Locy so loved his hobby of "stamp collecting" that he invented a classification system to help identify the postal cancellations used by the U.S. Navy. He did such a good job at developing his classification system that it was named after him when he died.

Francis Locy was born in Lake Forest, IL, on 20 December 1889. At the age of 27, he enrolled in the Naval Reserve as assistant surgeon. On 30 August 1917, he received

a commission as lieutenant junior grade. During World War I, Locy served with the 6th Regiment of Marines in France, and was awarded the Navy Cross and the French Croix de Guerre, with gilt star, for exceptional

bravery and fortitude under enemy fire. He was cited for operating his first aid dressing station at Belleau Wood and Chateau Thierry under constant threat of enemy machine gun fire and poison gas attack.

Returning to the United States in 1919, Dr. Locy was assigned to USS *Pennsylvania* (BB-38), and the Naval Hospitals at Washington, DC, and Great Lakes, IL. Further service was aboard the Navy's only hospital ship at the time, USS *Mercy* (AH-4), USS *Trenton* (CL-11), and the Naval Hospital at League Island, PA. During this period, he received successive promotions to assistant surgeon, with the rank of lieutenant, and naval surgeon, with the rank of lieutenant commander. In September 1929, he departed for Haiti for duty with the First Brigade, U.S. Marines.

It was during the 1920s that Dr. Locy began his extensive research and study



Photo courtesy of author

of U.S. Navy postmarks. He engaged in correspondence with the few other serious collectors of the time, and published articles on the subject in the philatelic publications of the period. In the February 1929 issue of the *American Philatelist*, official journal of the American Philatelic Society, he published an article outlining a classification system he had devised for government-issue postmarks used aboard ships of the U.S. Navy. The scholarly article was thoroughly researched and included illustrations of the postmarks in question. So careful was his study that the classification system he proposed, with only updates and revisions that the changes

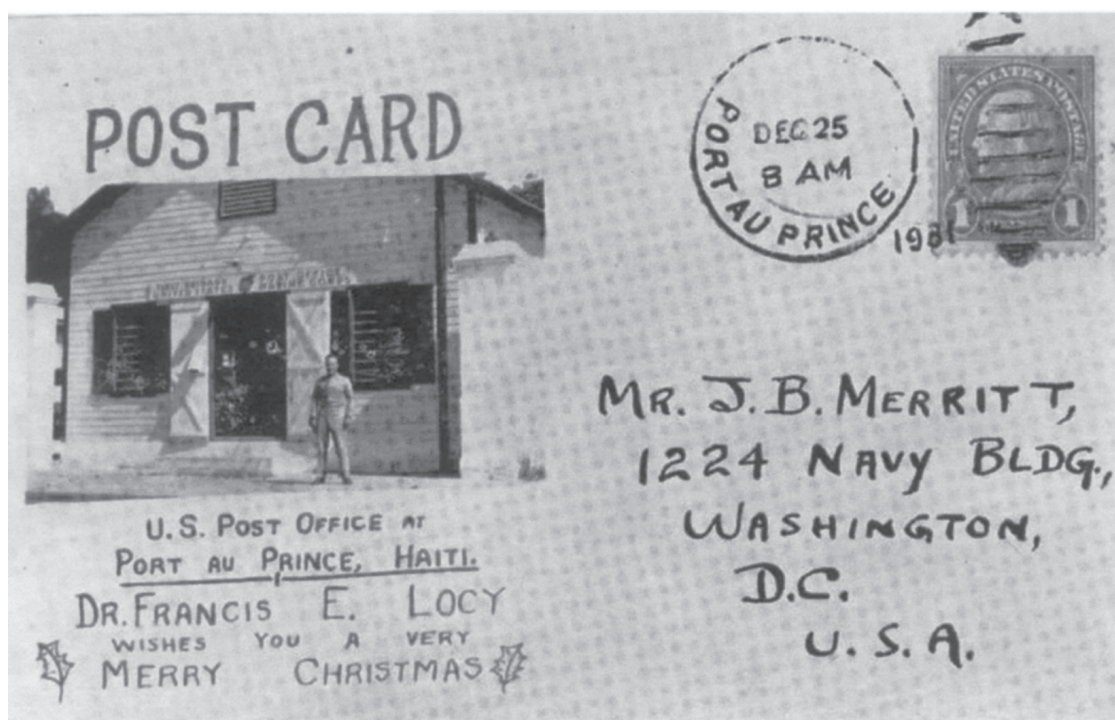
of the years have brought, is still in use today. We remember him by calling it the “Locy” system.

Dr. Locy’s system identified nine styles of postmarks issued through government channels. Later students have agreed that his Type 4 was really just a variation of the Type 3 cancel, and the Type 4 designation is no longer used. Locy also grouped all privately-made cancels under a classification that he called “fancy,” although even he agreed that many were rather plain. “Provisions 1” cancels were identified as those of original government issue that had been modified by the postal clerk in some way. He further described

minor variations in the postmarks by the use of small letters following the primary classification system.

In May 1932, Dr. Locy entered the League Island Naval Hospital as a patient. After several unsuccessful operations, he died at age 43 on 28 August 1932. He is buried in Arlington National Cemetery and his grave can be found in Section 7, Plot 9862. A hero of Navy medicine who served with honor with the Fleet and Marine Corps, Dr. Locy is remembered not only for his bravery in earning the Navy Cross, but also for leaving a permanent “postal” mark on American history and the hobby of stamp collecting. □

Dr. Norcross is Director, Current Operations & Platform Readiness Division (M3F3), Bureau of Medicine and Surgery, Washington, DC.



While stationed in Haiti in the early 1930's with the Marine Corps, Dr. Locy prepared a holiday greeting card with a postal cancellation for his friends and family back in the United States. The envelope cover featured here included a rare photograph of Dr. Locy

Competing Imperatives for Military Medicine at War

An Examination of the Potential for Moral Disengagement

CAPT Arthur M. Smith, MC, USNR (Ret.)

Allegations of Ethical Misconduct

Recent allegations of abuse of Iraqi prisoners in places such as Iraq's Abu Ghraib prison, and to a lesser extent within facilities in Afghanistan and Guantanamo Bay, have generally focused upon the activities of military intelligence and military police personnel. As yet unsubstantiated questions have also been raised concerning the alleged collaborative behavior of those who represent U.S. military medical services in these same locations. It has been argued that medical personnel in these facilities repeatedly failed to protect detainee's rights. Furthermore, it has been alleged that although knowledge of torture and degrading treatment was widespread at Abu Ghraib, and known to medical personnel, there is no report before the January 2004 Army investigation that military health personnel reported abuse, degradation, or signs of torture.^(1,2)

Medical personnel are likewise accused of having periodically collaborated with interrogators or abusive guards in helping, covering up, and standing by silently when humiliation, degrading treatment, and physical abuses took place. Medical personnel are derided for alleged complicity in evaluating detainees for interrogation, and collaborating with the design and implementation of psychologically and physically coercive interrogations. These accusations have also questioned the role of clinicians in monitoring interrogations; these physicians were supposedly placed in such situations as a safeguard. Critics state that this policy actually allowed medical judgment to be used in establishing the harshness of interrogation. Furthermore, military medical personnel are accused of having allowed interrogators to use medical records to develop interrogative approaches at Guanta-

namo Bay, where roughly 600 detainees had been held. Medical files were allegedly shared with interrogators, a practice that the International Committee of the Red Cross considers improper.^(1,2)

It has been further alleged that military medical personnel failed to do their duty under the Geneva Conventions to not only provide prisoners with monthly health inspections, but failed as well to develop a system for detainees to request medical assistance. Medical personnel are likewise condemned for not making provision for proper treatment of disabled prisoners, and for failing to investigate unexpected injuries or deaths caused by beatings of detainees in Afghanistan and Iraq. It was stated that they performed cursory evaluations only, attributing detainee deaths on death certificates to heart attacks, heat stroke, or natural causes without noting any unnatural etiology of the deaths. Furthermore, Abu Ghraib authorities were alleged to have failed to notify families of deaths, sicknesses, or transfers to medical facilities. Medical personnel in Afghanistan also stand accused of falsifying or delaying release of prisoner death certificates, as required by the Convention.^(1,2)

Given the shifting professional, behavioral, and ethical conflicts faced by healthcare personnel when transposed from a peacetime mode of medical practice to the exigencies of conflict, it behooves military behavioral theorists to delve ever more deeply into the personal and professional dynamics induced by the competing imperatives faced by medical personnel in wartime. A better understanding of the behavioral vulnerabilities and ethical choices of military medical personnel in wartime can only provide improved understanding, and better informed preparation of these highly trained and principled

men and women, as they face the difficult and confusing options that they will be obligated to exercise upon their entry into the theater of human conflict.

For the Healing Arts, War Is an Occasion of Contradiction

Traditionally, as military commanders begin implementing their grim responsibility both to engage in battles and to win them, the potential sacrifice of many young military personnel slowly evolves from theoretical possibility into reality. For most of its participants, war is an occasion of contradiction. Within modern society most young people are brought up with the belief that the worst of all crimes against civilization is the killing of another human being. Yet, through military service, many in our society have chosen, or if conscripted may become obliged, to participate in a process dedicated to terminating the lives of others in the name of defending or advancing national interests.

The role of the profession of military medicine poses challenges as well. Physicians give up a greater measure of autonomy over their choices and actions when they enter military service than they do in most other practice settings. Assumption of the mantle of a military physician entails subjecting oneself to potential conflict between commitment to the healing of individual patients on one hand, and responsibility to the military hierarchy and command structure on the other. In the absence of belligerency, a physician's primary professional obligation is to do everything in his/her power to preserve each patient's body in as near perfect working order as possible. The moral dilemma is that while during times of conflict the representatives of military medicine must, on one hand, attempt to mitigate the effects of war on individual participants, they are also expected to contribute to the more effective use of manpower by sustaining organizational combat readiness, and maximizing the fighting strength of the force. Stated otherwise, organizational obligations frequently take precedence over medical obligations, and the ability of military physicians to act on behalf of their patients is limited by their obligations to not only pursue military goals, but to also abide by military procedures and obey the lawful orders of superior officers. Sequestered during wartime within the subordinate framework of "logistics", the military medical officer exercises no authority comparable to that of a combat commander. His obligation, in the eyes of many senior line authorities, is "merely" to rescue, and then repair the damage sustained by those who have been offered up into harm's way. It is ultimately here, however, upon the battlefield, where the military physician's problem with conflicting loyalties begins to sharpen, since his/her collateral responsibility

to the combat arms commander is advisory, and clearly not that of a policy maker. (3)

Competing Imperatives

No physician can long work in a combat setting without an awareness of the important conflict of values and philosophies that profoundly affects his treatment of the combat injured. This dilemma pertains to the unique goals and objectives of the military casualty management system. On the one hand, the purely medical or human point of view is concerned with providing maximum medical and surgical aid at the earliest possible moment to the most gravely wounded, numbering many among them who will never return to fight. The purely "military view," however, is primarily concerned with the timely recuperation of the greatest number of wounded personnel and their restoration to their units with minimum delay. (This objective has been memorialized by the motto of the U.S. Army Medical Department, "To conserve the Fighting Strength").

No more graphic example of conflicting priorities exists than the frustrating allocation policy for penicillin among hospitalized American soldiers in North Africa during World War II. The drug was available in limited quantities only. Some patients suffered from battle wounds, and others were afflicted with venereal disease. Although battlefield casualties may have had a seemingly higher priority for receipt of the new "wonder drug," medical leadership mandated that only the troops with venereal disease would receive penicillin, notwithstanding the fact some of the wounded would die without it. As noted by Harvard's Dr. Henry Beecher, "Before indignation takes over, let us examine the situation. First, there were desperate shortages of manpower at the front. Second, those with broken bodies and broken bones would not be swiftly restored to the battle line, even with penicillin, whereas those with venereal disease, on being treated with penicillin, would in a matter of days free the beds they were occupying and return to the front." (4)

Treating wounded is primarily a matter of medical judgement. The problems may be difficult, but generally do not pose a clash of loyalties for the military physician until the number of casualties is great. Under the enormous pressure of casualty care in forward combat areas during major military engagements, however, it becomes impossible to completely satisfy both strictly military and medical philosophies. With increasing numbers of surviving casualties arriving by air all at once, while the number of wounded yet to arrive is indeterminate, where should the greatest effort and expenditure of resources be directed? Should it be to the gravely injured, or to those with minimal wounds who can be more surely returned

to the pursuit of war? In this setting, the physician will become obligated to make decisions NOT to devote effort to those whom he judges to have little chance of recovery, or to defer the treatment of those whose injuries would excessively consume the limited material and human resources available for care of many others with lesser injuries—the process universally known as “triage.” Generally, the implementation of such a treatment philosophy does not pass down from higher command authority. Regardless, the words of GEN George Patton in 1943, during a visit to medical officers in Casablanca, are starkly illustrative of command expectations: “If you have two wounded soldiers—one with a gunshot wound of the lung, and the other with an arm or leg blown off, you save the s.o.b. with the lung wound and let the g.d.s.o.b. with the amputated arm or leg go to hell. He is no g.d. use to us anymore!”(5)

Obligations

Military medical officers are not often free to choose how they will respond to a conflict between their military and medical obligations. Although military physicians may be in substantial agreement with the need for an effective fighting force, they may well have concerns about the effect of military decisions on health and well-being, especially of the service personnel who are their patients (notwithstanding their own ethical concerns regarding the treatment of prisoners of war and otherwise designated “detainees,” as well as displaced civilians). Their ability to act upon such comparisons, however, is generally constrained by the fact that they, too, have limited autonomy, and are obliged to obey military obligations and the orders of their superior officers. Although military medical officers may be granted wide discretion in making health decisions about individuals or groups under their care, when regulations or orders demand compliance, they may be forced to give their military obligations priority, no matter how strong their moral conviction that medical considerations should be given precedence. Superior orders may well take the decision out of their hands. As such, when issues and accusations arise relating to alleged torture, genocide, and mistreatment of one’s own soldiers, enemy prisoners of war, or civilians, they may be highly problematic under the ethical codes of medical practice.

The military demands a nearly total commitment to its goals and procedures, however, and military physicians have less individual freedom to make their own moral choices. In theory, they are obliged to obey all lawful orders that a superior might give. Occasionally, military physicians, might well refuse to obey an order they deem unlawful and request adjudication of the matter by a Court

Martial. Military physicians who take this step will, if the authorities decide to prosecute them, face the daunting task of convincing military judges that their interpretation of the applicable law, and not that of the commanding officer, is correct. To what laws may a physician appeal in challenging an order? Presumably, these include commonly recognized established standards of conduct emanating from well promulgated rules of military obligation, as well as the broader laws of one’s country, including international treaties such as the Geneva Convention that one’s own country has ratified. Thus, the scope of a military physician’s right to resist orders depends upon what regulations and laws one’s military service and one’s own nation have adopted, and these may vary significantly from one nation to another. Furthermore, even if nations have officially recognized an international law, they may not enforce it. (An occasional nation, for example, may permit widespread torture despite its acceptance of international laws that prohibit that practice.) In situations wherein an order violates international law but not national law, military physicians confront an unenviable choice between probable prosecution and disciplinary action by one’s own military for refusing to obey an order, yet face possible future prosecution and punishment by a foreign or international tribunal if they do implement the command.(6)

The Potential for Moral Disengagement

For physicians entering into military service, the requirements for certain qualities of character can never be supplied by governmental issue or authoritative fiat. Such intrinsic assets, combined, constitute the “ethos” of the military physician. These qualities are composed of the rather sublime traits of respect for human worth, humility, and an instinctive ability to discern the contrasting differences between that which is morally right and that which is wrong. These translate into the concepts of “do no harm” and “act for the best interests of the patient,” in addition to assuming certain obligations of confidentiality, truthfulness, and compassion. Such facets of “character” are not assumed following course work in professional schools, be they civilian or military. Rather, they are emblematic of an intrinsic ethical value system, founded upon a background of respect for moral principle. Certainly, the influences of parents, religion, and mentors all make their indelible molding imprint upon the physician’s character. Inevitably, however, the spiritual values of their culture, as well as their consciences, are the military physicians’ most durable, and probably only guides.

What then are the psychological mechanisms of moral disengagement that might potentially induce good people

to do evil, if allowed, and to be transformed into engaging in evil acts that are alien to their past history and to their moral development? Could it be that the power of situational forces, while not excusing the behaviors channeled by their operation, exert more power over human actions than has generally been recognized? In the form of a homily, “While a few bad apples might spoil the barrel filled with good fruit (or people), a vinegar barrel will always transform sweet cucumbers into sour pickles—regardless of the best intentions, resilience, and genetic nature of those cucumbers?”(7)

Recent accusations against military medicine imply that physicians brought a medical component to an “atrocious—producing situation”—one so structured, psychologically and militarily, that even ordinary people might readily engage in atrocities. It is implied that even without direct participation in the abuse, medical personnel became socialized to an environment of torture, and by their medical authority, helped sustain it. Furthermore, the alleged participation of physicians could indeed confer an aura of legitimacy and create an illusion of therapy and healing. It has been stated that the Nazis, for example, provided the most extreme example of physicians becoming socialized to atrocity. In addition to inhumane medical experiments, many Nazi physicians, as parts of military units, were directly involved in killing. They underwent first a sequence of socialization: first to the medical profession; then to the military where they adapted to the requirements of command; and finally to camps such as Auschwitz, where adaptation included assuming leadership roles in the existing “death factories”. The great majority of these physicians were ordinary people who had killed no one before joining the murderous Nazi institutions. The situation induced corruption of these individuals, and they became murderers, mainly in “atrocious producing situations.”(2)

Could emotional fatigue resulting from exposure to the grim realities of war provide an explanation? As described by one veteran wartime physician, character assets are akin to “moral capital.” The call on the bank might be the daily drain of casualty care, or intense emotional reaction to the sometimes grotesque wounds following bloody battles or suicide explosions. Perhaps it might be the experience of having been the subject of intense shelling or heavy bombing. Depletion may also evolve more slowly through monotony, perceived loss of support from superiors or colleagues, physical exhaustion, or a wrong attitude toward these dangers—or even to one’s paradoxical wartime missions. Alternatively, there may be a sudden emotionally traumatic major expenditure that threatens to “close one’s account.” When one’s moral or emotional capital is depleted, he or she is finished!(8)

Other potential explanations for acquiescence to the allegations of abuse and torture of “confinees” must be evaluated carefully as well. Social psychologists have shown, for example, that it is the group with which a person identifies, and not individual personality, that often determines behavior. To understand why people do as they do, one needs to look at the group with which they identify at the time. Social psychologists long ago determined that group norms may be more important than individual traits, and can trump individual personality to produce horrific behavior in ordinary people. Many psychology experiments have shown how easy it is for people to be manipulated into committing atrocities, such activities popularized in the lay media by the Nobel prize winning author William Golding’s novel, *Lord of the Flies*, demonstrating the transformation of good British choir boys into murderous beasts. In the well known yet controversial “Stanford University Experiment” in 1971, for example, 24 normal college age men were assigned to be either guards or prisoners. Within the investigational setting, the “guards” quickly became sadistic, engaging in what Stanford University psychologist Philip Zimbardo called, “pornographic and degrading abuse of the prisoners.” Pacifist young men empowered as “guards” inflicted humiliation, pain, and suffering upon other young men if they had the inferior human status of “prisoner.” Some “guards” even reported enjoying doing so. As such, the 2-week experiment had to be terminated after only 6 days because of the pathologic behavior being witnessed. Critics have implied that this potentially identical mechanism presaged the alleged behavior of American troops, including medical personnel, at Abu Ghraib prison.(7)

Moral Abdication?

Although the horrors of the Holocaust occurred in Europe many years ago, they continue to affect discussions of medical ethics today. During the 1930s, the German medical establishment was admired as a world leader in innovative public health and medical research. A major question debated by historians is how science became co-opted in such a way that physicians as healers evolved into killers, and medical research became torture. Many of today’s most important issues in medical ethics—from genetic testing and stem cell research, to caring for prisoners of war—are directly affected by the experiences of medicine leading up to and during the Holocaust. Indeed, one reason why many young activist physicians today are so concerned about racial and ethnic health disparities is because commonly accepted codes of medical ethics demand that every person be treated equally, without regard to race or ethnic background. This ethical obligation is a direct outgrowth of reaction to the horrors of

Nazi medicine, and to the less well known but equally egregious offences of Japanese military physicians prior to and during World War II, while implementing involuntary biological warfare experimentation upon human subjects in occupied Manchuria.

It has been proposed by critics of the Abu Ghraib revelations that while military physicians can be placed in a difficult position, they must first and foremost be concerned about their patients, and not participate in or facilitate torture, or other forms of cruel, inhumane, and degrading procedures upon prisoners or detainees. Healthcare workers who have witnessed abuses are urged to break their silence and protest loudly, while ethically refusing cooperation with such practices. Unfortunately, these accusers of the U.S. military medical presence at confinement facilities demand the application of abstract principles of justice that, sadly, are often neither practical nor realistic, and are not necessarily synonymous with American national interests. (Ironically, those being accused are representatives of the very same groups of military physicians and healthcare personnel who have frequently provided lifesaving care and treatment to hundreds, and perhaps thousands of insurgent Iraqis and terrorist detainees, as well as untoward numbers of displaced citizens of Iraq and Afghanistan, often at a standard comparable to those for U.S. personnel.)

Conclusions

Recent allegations of moral disengagement attributed to United States military medical personnel at confinement facilities in Iraq, Afghanistan, and at Guantanamo Bay, although unproven and uncorroborated at present, should prompt at least an analysis of the conflicting roles born by representatives of military medicine in operational theaters. Some fear that the evolution of an "all volunteer force" has created in the U.S. a military caste dissociated from the remainder of society, characterized by the loss of civic virtue and national values. It is clearly evident, however, that peacetime ethical standards cannot be broadly applied to a wartime scenario, where mission priorities remain dominant. Furthermore, new challenges will continue to be faced, such as, for example, orders to facilitate the political implementation of military medical services strictly to "win the hearts and minds" of targeted populations, or requirements to participate in development of offensive weaponry. How can these be dealt with if moral challenges arise?

The practitioners of military medicine in wartime must remain ever sensitive to the potential for "crossing the Rubicon" into the zone of irrefutable moral disengagement, despite the unique conditions of armed conflict. The ultimate key to moral self-realization is through educational efforts designed to inculcate in military medi-

cal practitioners a problem solving approach to ethical behavior in unfamiliar or unanticipated circumstances. (Since its inception, for example, the Uniformed Services University of the Health Sciences has taught students, through didactic and seminar format, the importance of ethical analysis in the conflicted setting.) It would clearly be impractical to anticipate universal training in moral self-analysis among all military healthcare providers. Nevertheless, it would constitute a major oversight to disregard the necessity for formal educational preparation of military medical leadership, leading toward greater recognition of the tough ethical realities of wartime medicine. The ultimate goal is the concurrent development in them of the capability to deal with ethical crisis analysis. It is to be hoped that through the development of such capabilities within the senior management of wartime medical services, that the same analytical precepts will ultimately be extended to implementation by all those individuals who execute the command mandates of both combat arms and medical leadership.(9)

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In Memoriam

Former LT Marilyn E. Affleck, NC, USNR, died on 14 November 2004 at her home in Woodbridge, VA. She was 79.

Marilyn Affleck was born in West Virginia and graduated nursing school at East Liverpool, Ohio City Hospital in 1943, the same hospital her mother, also a nurse, attended just after World War I.

She joined the Navy in 1948 and was assigned to Naval Hospital Great Lakes, IL. Her next assignment was Naval Hospital Camp Pendleton, CA, where she was stationed when the Korean War broke out in June 1950. "We saw boys on the buses going to Korea and they would throw their letters out and ask us to mail them for them. They left Pendleton by the busloads."

It wasn't long before LT Affleck received orders to U.S. Naval Hospital Yokosuka, Japan, where she was at work just hours after arriving, caring for the many wounded coming in from the Korean front.

"They had a lot of young men there in the hospital, three high in some bunks on our wards. The ones that could move were on the top



bunk and the one ones who couldn't were on the bottom bunk where we could handle them."

In the first weeks of December 1950, the hospital was deluged by a flood of casualties from the Chosin Reservoir campaign. Suddenly the census rose from relatively few patients to over 3,000. The troops had experienced combat in North Korea during one of the coldest winters in memory with temperatures dropping as low as 35 degrees below zero.

Many of LT Affleck's patients were horribly frost-bitten. "I remember we would soak their feet in a basin of warm water and use our bandage scissors to scrape the black crud, calluses, and stuff off their feet. Those kids really had a hard time."

Marilyn Affleck left the Navy in 1956 to marry. In 1970, she returned to nursing as a civilian, and retired from the staff of Naval Hospital Quantico in 1985.

As a veteran of what has often been called "The Forgotten War," Marilyn Affleck organized Korean veterans' reunions and luncheons, and worked tirelessly collecting information for the book, *Quiet Heroes: Navy Nurses of the Korean War 1950-1953*, by Frances Omori. In 2003 she traveled to South Korea as a guest of the South Korean government and helped represent Navy nurse veterans at the 50th anniversary of the Korean War commemoration in Seoul.

To the end of her life, Marilyn Affleck represented the best of what Navy nurses are and have been—dedicated, resourceful, spirited, and caring. We will miss her. □

HMC Chester K. Fast, USN, died on 21 October 2004 in Springfield, MO. Master Chief Fast was a World War II veteran and a survivor of the notorious Japanese hell ship, *Oryoku Maru*.

On the eve of the war, Pharmacist's Mate Fast was stationed in the Philippines and became a captive when all U.S. forces surrendered to the Japanese. He and his comrades were then held at the infamous Bilibid Prison in Manila.

In November 1943 the Japanese took him and a draft of men to the former island fortress of Corregidor in Manila Bay to play the part of actors and extras for a film they were making depicting the Japanese victory in the Philippines. The script was simple. For the camera, Japanese soldiers and Americans playing themselves were to reenact GEN Jonathan Wainwright's surrender of Corregidor. Scenes shot there would be spliced to others filmed at Bataan in what would become "Down With the Stars and Stripes," a propaganda motion picture to be shown to Japanese audiences. Pharmacist's Mate Fast had his acting debut in the film playing the roles of a soldier guarding one of the

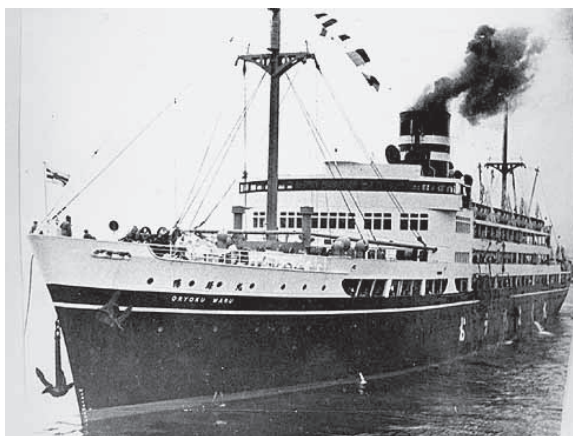
tunnels, GEN Wainwright's chauffeur, and his military aide.

"They had a script. In one scene, they had a bunch of us running out of one of the caves. I was standing in the cave with a rifle. They lined us up in one of the tunnels and then had a group come out. Jim Bray [PhM2c James F.] played the part of "Skinny" Wainwright. I was his aide and a major. The big scene was Jim and I walking out of the tunnel waving a white flag. Then they filmed a scene where we all marched up with the American flag and met the Japanese officers. Of course, we had to speak English. Whatever they said was in their language. In another scene I was driving the big limousine. Showing the same face playing different roles didn't seem to make any difference to

them. We were over on Corregidor about 3 days and then returned to Bilibid. None of us ever saw the movie but our Bilibid guards did and teased me about it. One recognized me and said, "Ah, cinema, cinema." It was very amateurish but an interesting adventure."

When American troops invaded the Philippines in late 1944, the Japanese packed cargo ships with Allied prisoners for shipment to Japan to be used as slave laborers. These ships were unmarked and many succumbed to U.S. planes and torpedoes. With virtually no food and almost no air, the squalid holds of these vessels became death traps for the thousands of prisoners packed into them. Pharmacist's Mate Fast was one of the few survivors of the *Oryoku Maru*, bombed and sunk by carrier based Navy planes just off the Philippine coast. Eventually imprisoned in Japan, he was finally liberated at the end of the war. He continued with his Navy career, serving for 20 years before retiring in 1960.

Navy Medicine interviewed HMC Fast last spring for BUMED's new video release, "Guests of the Emperor," in its *Navy Medicine at War* series. □



The *Oryoku Maru* was a Japanese luxury liner before it was a prison ship. Photo from www.oryokumaru-online.org.

Letters to the Editor

I read the article "Reducing Unplanned Pregnancy Among Active Duty Sailors" (Navy Medicine, Sep-Oct, pages 7-10) by Mr. MacDonald and CAPT Bohnker, and believe some additional information should be shared with your readers to put the 2003 Pregnancy and Parenthood Survey results discussed in the article in fuller context.

1. Impact of Unplanned Pregnancies:

The 2003 survey results indicate that 30 percent of enlisted women who became pregnant in FY02 planned their pregnancy. For enlisted women who have ever been pregnant while in the Navy, 35 percent planned their most recent pregnancy. Both these rates include all women, regardless of their marital status at time of pregnancy. When examining planning by marital status, 14 percent of single/divorced enlisted women and 59 percent of married enlisted women who have ever been pregnant while in the Navy planned their most recent pregnancy. Additionally, the survey did not assess marital status at time of childbirth; it is possible that some of those single when they became pregnant did not become single parents and conversely those married when they became pregnant may not have become married parents. An unplanned pregnancy carried to term may not always result in a single parent.

2. Pregnancy Rates: The Pregnancy and Parenthood Survey was administered in 1988, 1990, and 1992, and has been administered biennially since 1997. Although some of the questions have been removed and new questions added over those years, key questions have remained the same for the last several survey administrations, including those assessing pregnancy. For the point-in-time snapshot of enlisted pregnancy, the 6.9 percent rate of the 2003 survey administration is similar to the 8.6 percent rate found in 1988 (Thomas & Edwards, 1989). The annualized rate captures those who became pregnant in the previous FY; in 2003 this rate was 13 percent, similar to the 16 percent found during the 1997 survey administration. Looking at the

The following clarifications to the article "Reducing Unplanned Pregnancy Among Active Duty Sailors" (Navy Medicine, Sep-Oct, pages 7-10) are insights provided by the principal investigator of the most recent Navy parenting and pregnancy surveys.

- Of those who experienced a pregnancy in FY2002, 30 percent of enlisted women planned the pregnancy (as shown in Figure 1).

- For the most recent pregnancy experienced by those ever pregnant while in the Navy, 73 percent of enlisted members surveyed in 2001 said the father was a military man.

- About half the enlisted female Sailors that experienced an unplanned pregnancy were married during their most recent pregnancy (49 percent).

- Among male enlisted Sailors, one of four single fathers with custody in 2001 was unmarried.

- In 2001, 73 percent of female enlisted single parents said they plan to move their children when they deploy.

- Navy policy reassigns Sailors off ships before the end of the 20th week of gestation.

- Pregnancy and parenting survey data cited as 2002 were collected in 2003. Thanks very much.

Michael R. MacDonald, Public Health Educator, NEHC, Portsmouth, VA.

entire history of the survey results, it can be seen that Navy pregnancy rates have remained stable over time.

3. Single Parenthood: The percentage of Navy women who are single mothers has dropped from 13 percent on the 1999 survey administration to 9 percent on the 2003 survey administration while the percentage of non-parent women has increased from 61 percent in 1999 to 68 percent in 2003. While the 9 percent single-parent rate for women is larger than the 3 percent rate for men, when using 2003 population numbers, this means the Navy has about 10,000 single fathers and about 5,000 single mothers due to the demographic makeup of the Navy (about 85 percent male, 15 percent female). So while the focus may be on the higher percentage of women than men who are single parents, numerically there are about twice as many male single parents in the Navy as females.

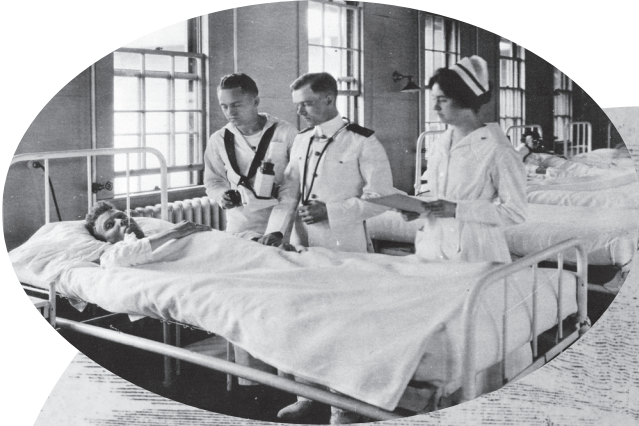
4. Best Time to Become Pregnant: One survey question asked, "When in her Navy career is the best time for a woman to become pregnant?" Answer choices ranged from "Never. Being in the Navy and motherhood are not compatible" to "Whenever the woman wants a child." Of note is the agreement with the choice "Whenever the woman wants a child" for female enlisted. Agreement for this group was at 33 percent in 1997 and has steadily declined to 23 percent agreement in the 2003 survey.

5. Birth Control Use: The 2003 survey asked, "Do you or your partner usually use a form of birth control (including tubal ligation or vasectomy)?" This question has changed slightly over the years to stay current with available medical options. In 1997, sterilization was a separate question and the results of the two questions combined to yield an overall birth control usage rate of 77 percent for male enlisted and 77 percent for female enlisted. In 2003, sterilization was part of the question, yielding usage rates of 71 percent for male enlisted and 75 percent for female enlisted, indicating that usage of birth control has remained steady for female enlisted while it has shown a slight decrease for male enlisted.

Sincerely,

Zannette A. Uriell, Pregnancy and Parenthood Project Director
Navy Personnel Research, Studies, and Technology
Navy Personnel Command
Millington, TN.

Navy Medicine 1836-1974



Naval Hospital Chelsea, MA.

Situated along the banks of the Mystic River in a suburb north-east of Boston. Naval Hospital Chelsea was commissioned on 7 January 1836.

In the 19th century the facility earned a reputation as the only naval hospital on the Atlantic Coast to be entirely free from malaria. This rendered it a desirable place for the treatment of the Navy malarial patients from southern cruises.

During World War II, LT John F. Kennedy was a patient there. The hospital was disestablished on 28 June 1974.

Photos from BUMED archives.



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